CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 743

Department of Health & Human Services (DHHS)

Center for Medicare & Medicaid Services (CMS)

Date: NOVEMBER 4, 2005

Change Request 4123

SUBJECT: Remittance Advice Remark Code and Claim Adjustment Reason Code Update

I. SUMMARY OF CHANGES: This contains information about reason and remark code changes approved from March 2005 through June 2005. Medicare contractors shall update their remittance advice maps/matrices as appropriate to incorporate those changes that impact their electronic and paper remittance advice, and coordination benefits transactions.

NEW/REVISED MATERIAL

EFFECTIVE DATE: January 1, 2006

IMPLEMENTATION DATE: January 3, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title

N/A

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Recurring Update Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Recurring Update Notification

Pub.100-04	Transmittal: 743	Date: November 4, 2005	Change Request 4123

SUBJECT: **Remittance Advice Remark Code and Claim Adjustment Reason Code Update**

I. GENERAL INFORMATION

A. Background: Per the Health Insurance Portability and Accountability Act (HIPAA) of 1996, health plans must be able to conduct standard electronic transactions for transactions mentioned in the regulation using valid standard codes. Claim Adjustment Reason Codes (CARC) are required to be used in remittance advice and coordination of benefits transactions, and Remittance Advice Remark Codes (RARC) are required to be used in remittance advice transaction.

X12N 835 Health Care Remittance Advice Remark Codes

CMS is the national maintainer of the remittance advice remark code list that is one of the code lists mentioned in the ASC X12 transaction 835 (Health Care Claim Payment/Advice) version 4010A1 Implementation Guide (IG). Under HIPAA, all payers, including Medicare, have to use reason and remark codes approved by X12 recognized code set maintainers instead of proprietary codes to explain any adjustment in the payment. As the X12 recognized maintainer of the RARC, CMS receives a significant number of requests for new remark codes and modifications in existing remark codes from Medicare and non-Medicare entities. Additions and modifications to the code list resulting from non-Medicare requests may not impact Medicare.

Traditionally, remark code changes that impact Medicare are requested by Medicare staff in conjunction with a policy change. Contractors are notified of those new/modified codes in the corresponding implementation instructions, which implement the policy change, in addition to the regular code update notification. If a modification has been initiated by an entity other than Medicare for a code currently used by Medicare, contractors shall use the modified code even though the modification was not initiated by Medicare. If a new code is not initiated by Medicare, contractors do not have to use it unless otherwise instructed by Medicare. Contractors shall stop using codes that have been deactivated on or before the effective date specified in the comment section if they are currently being used. The complete list of remark codes is available at:

http://www.wpc-edi.com/codes

NOTE: If you find any discrepancy between any code text included in this CR and the corresponding text as posted on the Washington Publishing Company (WPC) Web site, use the text posted at the WPC Web site.

The list is updated 3 times a year. By January 3, 2005 you must have completed entry of all applicable code text changes and new codes, and terminated use of deactivated codes. You must use the latest approved and valid codes in your 835, corresponding standard paper remittance advice, and coordination of benefits transactions. The following list summarizes changes made from March 1, 2005 to June 30, 2005.

Remittance Advice Remark Code changes

New Codes

Code	Current Narrative	Medicare Initiated
N348	You chose that this service/supply/drug/ would be rendered/supplied and billed by a different practitioner/supplier.	Y
N349	The administration method and drug must be reported to adjudicate this service.	N
N350	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or an Unlisted procedure.	N
N351	Service date outside of the approved treatment plan service dates.	N
N352	There are no scheduled payments for this service. Submit a claim for each patient visit.	N
N353	Benefits have been estimated, when the actual services have been rendered, additional payment will be considered based on the submitted claim.	N
N354	Incomplete/Invalid invoice.	N

N355	The law permits exceptions to the refund requirement in two cases: - If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or - If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service. If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days of the date of this notice. Your request for review should include any additional information necessary to support your position. If you request an appeal within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision. The law also permits you to request an appeal at any time within 120 days of the date you receive this notice. However, an appeal request that is received more than 30 days after the date of this notice, does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination. The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact our office if he/she does not hear anything about a refund within 30 days.	Y
N356	This service is not covered when performed with, or subsequent to, a non-covered service.	N

Modified Codes

Code	Current Modified Narrative	Modification Date
N21	Your line item has been separated into multiple lines to expedite handling.	Modified eff. 8/1/05

M25	Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date you received this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.	Modified eff. 8/1/05
M26	Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office.	Modified eff. 8/1/05
M27	The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.	Modified eff. 8/1/05

MA01	If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.	Modified eff. 8/1/05
MA02	The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact our office if he/she does not hear anything about a refund within 30 days.	Modified eff. 8/1/05
MA03	If you do not agree with the approved amounts and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing within six months of the date of this notice. To meet the $100, you may combine amounts on other claims that have been denied, including reopened appeals if you received a revised decision. You must appeal each claim on time. At the reconsideration, you must present any new evidence which could affect our decision.	Modified eff. 8/1/05
MA83	Did not indicate whether we are the primary or secondary payer.	Modified eff. 8/1/05
MA94	Did not enter the statement "Attending physician not hospice employee" on the claim form to certify that the rendering physician is not an employee of the hospice.	Modified eff. 8/1/05
N122	Add-on code cannot be billed by itself.	Modified eff. 8/1/05
N125	Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. If you have collected any amount from the patient, you must refund that amount to the patient within 30 days of receiving this notice. The requirements for a refund are in §1834(a) (18) of the Social Security Act (and in §§1834(j) (4) and 1879(h) by cross-reference to §1834(a) (18)). Section 1834(a) (18) (B) specifies that suppliers which knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare program. If you have any questions about this notice, please contact this office.	Modified eff. 8/1/05

N29	Missing documentation/orders/notes/summary/report/chart.	Modified eff. 8/1/05
N225	Modify N225 - Incomplete/invalid documentation/orders/notes/summary/report/chart.	Modified eff. 8/1/05
M23	Modify M23 - Missing invoice. New - Incomplete/invalid invoice.	Modified eff. 8/1/05

Deactivated Codes

None

X12 N 835 Health Care Claim Adjustment Reason Codes

A national code maintenance committee maintains the health care claim adjustment reason codes. The Committee meets at the beginning of each X12 trimester meeting (February, June and October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted 3 times a year after each X12 trimester meeting at http://www.wpc-edi.com/codes. Select Claim Adjustment Reason Codes from the pull down menu. All reason code changes approved in June 2005 are listed here. By January 3, 2006, you must have completed entry of all applicable code text changes and new codes, and terminated use of deactivated codes. You must use the latest approved and valid codes in your 835, corresponding standard paper remittance advice, and coordination of benefits transactions.

The request for a reason code change may come from non-Medicare entities. If Medicare requests a change, it may be included in a Medicare instruction in addition to this regular code update notification. The regular code update notification is issued on a regular periodic basis to provide a summary of changes in the reason and remark codes introduced since the last update notification, and **will establish the deadline for Medicare contractors to implement the reason and remark code changes that may not already have been implemented as part of a previous Medicare policy change instruction.**

A reason code may be retired if it is no longer applicable or a similar code exists. Retirements are effective for a specified future and succeeding versions, but contractors can also discontinue use of retired codes in prior versions. The regular code update notification will establish the deadline for Medicare contractors to retire a reason code that could be earlier than the version specified in the Washington Publishing Company (WPC) posting. The committee approved the following reason code changes in June 2005.

Reason Code Changes

New Codes

Code	Current Narrative	Notes
167	This (these) diagnosis(es) is (are) not covered.	New as of 6/05
168	Payment denied as Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan	New as of 6/05
169	Payment adjusted because an alternate benefit has been provided	New as of 6/05
170	Payment is denied when performed/billed by this type of provider.	New as of 6/05
171	Payment is denied when performed/billed by this type of provider.	New as of 6/05
172	Payment is adjusted when performed/billed by a provider of this specialty	New as of 6/05
173	Payment adjusted because this service was not prescribed by a physician	New as of 6/05
174	Payment denied because this service was not prescribed prior to delivery	New as of 6/05
175	Payment denied because the prescription is incomplete	New as of 6/05
176	Payment denied because the prescription is not current	New as of 6/05
177	Payment denied because the patient has not met the required eligibility requirements	New as of 6/05
178	Payment adjusted because the patient has not met the required spend down requirements.	New as of 6/05
179	Payment adjusted because the patient has not met the required waiting requirements	New as of 6/05
180	Payment adjusted because the patient has not met the required residency requirements	New as of 6/05
181	Payment adjusted because this procedure code was invalid on the date of service	New as of 6/05
182	Payment adjusted because the procedure modifier was invalid on the date of service	New as of 6/05
183	The referring provider is not eligible to refer the service billed.	New as of 6/05
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	New as of 6/05
185	The rendering provider is not eligible to perform the service billed.	New as of 6/05
186	Payment adjusted since the level of care changed	New as of 6/05
187	Health Savings account payments	New as of 6/05
188	This product/procedure is only covered when used according to FDA recommendations.	New as of 6/05

189	"Not otherwise classified" or "unlisted" procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service	New as of 6/05
D21	This (these) diagnosis(es) is (are) missing or are invalid	New as of 6/05

Modified Codes

Code	Current Modified Narrative	Notes
23	Payment Adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments.	Modified 6/05

Retired Codes

Code	Current Narrative	Notes
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	Inactive as of 2/2006
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.	Inactive as of 2/2006
B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.	Inactive as of 2/2006

In the September meeting, the Claim Adjustment Status Code Maintenance Committee approved a code that is going to be used by providers who must submit claims electronically under Administrative Simplification Compliance Act (ASCA) when a) Medicare is not primary payer, and b) providers have received paper remittance advice containing proprietary codes from the previous payer(s). This generic code would allow providers to sum all adjustment amounts corresponding to one specific group code e.g., CO, and use that total amount with group code CO and this new code.

New Reason Code: 192 Non-standard adjustment code from paper remittance advice.

By January 3, 2006, you shall complete entry of this new code as a valid code, and make sure that claims that contain this code are accepted for adjudication.

B. Policy: For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, there are two code sets – Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) – that must be used to report payment adjustments, appeal rights, and related information. Additionally, for transaction 837 COB, CARC must be used. These code sets are updated on a regular basis. Medicare contractors must use only currently valid codes, and make the necessary changes on a regular basis as per this recurring code update CR or the specific CR that describes the change in policy that resulted in the code change.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4123.1.1	Intermediaries/RHHIs/Carriers/DMERCs and VMS shall update reason and remark codes that have been modified and which apply to Medicare by January 3, 2006.	X	X	X	X			X		
4123.1.2	Intermediaries/RHHIs/Carriers/DMERCs, and VMS shall add new reason and remark codes that are applicable to Medicare by January 3, 2006.	X	X	X	X			X		
4123.1.3	Intermediaries/RHHIs/Carriers/DMERCs shall furnish provider education about changes in claim adjustment reason and remittance advice remark codes. Contractors shall post the above mentioned MedLearn article, or a direct link to the article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin.	X	X	X	X					

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4123.2	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider	X	X	X	X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2006 **Implementation Date:** January 3, 2006 **Pre-Implementation Contact(s):** Sumita Sen at Sumita.sen@cms.hhs.gov or 410-786-5755 **Post-Implementation Contact(s):** Sumita Sen at Sumita.sen@cms.hhs.gov or 410-786-5755	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

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